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TECHNICAL REPORT: HIV COUNSELING AND TESTING IN KYRGYZSTAN, KAZAKHSTAN AND TAJIKISTAN

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The USAID Quality Health Care Project is a five-year program designed to improve the health of Central Asians by strengthening health care systems and services, particularly in the areas of HIV/AIDS and TB care and prevention. The project assists governments and communities to more effectively meet the needs of vulnerable populations, with the aim of increasing utilization of health services and improving health outcomes. The Quality Health Care Project is part of USAID's third objective of investing in people as part of the US Strategic Framework for Foreign Assistance.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
DFID	UK Department for International Development
FMC	Family Medical Center
FGP	Family Group Practice Centers
GFATM	Global Fund to Fight AIDS, TB and Malaria
HCT	HIV Counseling and Testing
IDU	Injecting Drug User
MARP	Most At-Risk Populations
MSM	Men who have sex with men
PICT	Provider Initiated Counseling and Testing
PLHIV	People living with HIV
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

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EXECUTIVE SUMMARY

This report details findings from the recent technical assistance provided by Quality Health Care Project in the Central Asian Republics. The assistance focused on the provision of technical updates on voluntary counseling and testing (VCT) and provider-initiated counseling and testing (PICT) to a range of key stakeholders working in health services in Kazakhstan, Kyrgyzstan, and Tajikistan. In addition, a baseline assessment was conducted of HIV Counseling and Testing (HCT) in eight sites.

This report provides a background to the current status of HIV counseling and testing in these countries: it details the findings, challenges and achievements for HCT and suggests recommendations for continuing technical assistance for the Quality Health Care Project.

METHODOLOGY

The aims of the HIV counseling and testing technical assistance in Kyrgyzstan, Kazakhstan and Tajikistan were two-fold:

- To provide an opportunity for roundtable meetings with relevant stakeholders: health workers and representatives from local and international NGOs. These meetings were designed as educational forums: to present information and updates on improving uptake of VCT and alternative models, and to facilitate participants' frank exchange of ideas on the current status and future needs of VCT and PICT.
- To gather information from key stakeholders within each country on the challenges faced in the provision of quality VCT and PICT, in particular for the groups most affected by HIV: injecting drug users (IDU), sex workers and men who have sex with men (MSM). Stakeholders interviewed included: health facility managers and directors, health workers and NGOs working with and/or led by MARPs. One-to-one interviews, group interviews and focus groups were conducted in the three countries in high HIV prevalence areas, prior to selecting localities for Quality Project's work.

BACKGROUND

Most-at risk populations (MARPs) in Central Asia – including injecting drug users (IDU), sex workers, men who have sex with men (MSM), prisoners and migrant workers – have not benefited from the availability of VCT to the same extent as other members of the population, despite the availability of VCT for 15 years. Currently there is much greater recognition at the national and regional levels, that VCT and PICT should be targeted towards these vulnerable groups.

Quality Health Care Project (Quality Project) will work in an initial nine selected localities – three in each country – to increase access for MARPs to improved quality HIV services, and to provide input from these experiences to national policy and programming. The Quality Project will work in each of these localities with key health facilities (entry points to the health system, at which MARPs seek care), the NGOs that work with those facilities, and the NGOs' clients. The localities chosen by the Quality Project will allow multiple services (NGOs and health facilities) to be targeted concurrently, will provide a replicable model for system strengthening, and will enable clients to have access to a broad range of better quality services.

There have been substantial efforts in recent years through donor-funded programs and through the work of national ministries of health, to transform the vertical structure of the health services in the three countries, to a more family medicine-oriented provision of services. This has succeeded to a lesser or greater extent, depending on the level of support received, and the motivation of health managers and health workers. In many locations, little appears to have changed from the era of the Soviet style vertical health system. This is true in terms of management systems, the attitude of health workers and even the buildings themselves (clinics that have not been renovated and have no extra space),

Where change has occurred in the health system, HCT has benefited from this process of change. Funding from Global Fund grants has helped to expand HCT in Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan. In Kazakhstan and Tajikistan the number of health facilities providing VCT increased by between 50% and 100% from 2007 to 2008.[1] [1]However, the quality of HCT varies considerably, as does the uptake of VCT by people from MARPs. Mandatory testing of some groups of people continues, including for pregnant women and female prisoners.

Trust points (offices in health facilities focused on the needs of IDU) and friendly offices (most often focused on sex workers) have been established in recent years, in an effort to encourage clients from vulnerable populations to go for VCT. MSM remain almost completely hidden in parts of Kyrgyzstan and Tajikistan, and are heavily stigmatized in all three countries. There are no MSM-specific friendly offices in health services.

FINDINGS

The quality of VCT is dependent on a close working relationship between NGOs working with MARPs and selected medical services, rather than on a whole-of-system strengthening approach. In many instances, the NGO and health facility will establish an agreement, whereby health facilities undertake to provide quality services for MARP clients. This may be accompanied by a referral system that comprises a referral form (or "voucher"), as an entrée into the service and a guarantee of better service. In some situations, however the referral form alone is not sufficient and the client can only ensure a quality service if accompanied by an NGO staff member.

Payment for services is common and this includes VCT, which is mandated to be free in all of the countries visited. Informal payments are expected by many health workers to supplement their salary. Some groups of clients accept this; others such as IDU, who usually have no money, find this a barrier to access services.

Improved communication skills training are an identified need by medical staff. Training in VCT has generally been theoretical and based more on the need to collect data and register people who test positive, than on the development of the counseling skills that should accompany HIV testing. While some health workers interviewed said they had received training in PICT, it is rare that health workers initiate a discussion about HIV. There was no evidence of comprehensive risk assessment in any centers visited. A passive approach to consent for testing, involved giving the client an information sheet and asking the client to sign it. Only if the client asked questions, would any discussion take place. Many health workers said they would welcome training in communication skills enabling them to address difficult or taboo topics with clients including taking a full risk assessment.

1. [1] Thorne, C., Ferencic, N., Malyuta, R., Mimica, J. and Niemiec, T. *Central Asia: Hotspot in the Worldwide HIV Epidemic.* (2010). The Lancet Infectious Diseases (10) 479-488.

Health worker workload is a considerable barrier to improving the quality of counseling for VCT. Many health staff interviewed said they did not have time to provide the appropriate level of counseling needed in VCT. Emphasis is on tracking clients who test HIV positive but little attention is placed on risk reduction counseling for clients who test HIV negative. NGOs sometimes fill this role.

Confidentiality and non-disclosure of positive status of clients are not well understood in some settings, even in centers that provide counseling and testing. The emphases are on surveillance rather than testing as a pathway to treatment, care and support.

Access to rapid HIV tests is called for by many NGO staff to perform the client's first HIV test. It is believed this would increase uptake of VCT and reduce the number of people lost to follow up.

Stock-outs of essential protective equipment for staff (gloves and goggles) were a regular feature in one site visited. Occupational health and safety and infection control was a concern and may well be an issue in other settings.

RECOMMENDATIONS

TRAINING

- Develop a short course on basic communication skills and skills specific to VCT and PICT, and rolled it out to the frontline workers (doctors and nurses) currently involved in HCT at trust points, friendly offices, FMC FGP and dispensary level (where dispensaries exist in the localities). Refresher trainings should be organized in Year Two.
- Offer trainings for health workers to address stigma and discrimination – this would be tailored to the needs of the locality, for example in Tajikistan and the southern part of Kyrgyzstan, stigma and discrimination against MSM is particularly severe and needs specific address.
- Consult with the appropriate regulatory body for medical and nursing education, to discuss the development of pre-service trainings for doctors and nurses in HCT and communication skills.
- Write a curriculum on HCT that includes: addressing stigma and discrimination (especially in relation to most-at-risk populations), and teaches communication skills. Curriculum to be developed in consultation with the appropriate health faculty for pre-service education for doctors and nurses.
- Translate material resources – client informational materials, HCT training materials, clinical guidelines and protocols and medical handbooks into local languages, and produce low-literacy information resources on HCT.

QUALITY ASSURANCE AND SUPERVISION

- Develop and roll out a system of mentoring and clinical (supportive) supervision for doctors involved in VCT in one or two health facilities in each of the Quality Project localities, with an aim to expand to all health facilities within the localities in Year 2.
- Develop a standardized risk assessment pro-forma. Health workers who have undergone training in communication skills should receive additional training on the use of the risk assessment.
- Develop a monitoring and evaluation system focusing on the quality of HCT based on qualitative indicators and measures.

- Develop a post-training evaluation for implementation after three months with clinicians who have received training in communication skills (as described above).
- Expand the system of mentoring and clinical (supportive) supervision for doctors involved in VCT to all Quality Project localities. Mentoring and clinical supervision for nurses in facilities in the localities should be included as part of a larger strategy of task shifting.
- Collaborate with representatives of health services and NGOs to define and then implement quality services (such as partnership-defined quality).

REVIEW OF REFERRAL SYSTEMS

- Thoroughly review referral systems, including individual NGOs' referral forms, and the current practice of escorting clients to clinics in Year 1 and continue into Year 2. The review should be conducted, in collaboration with NGO staff, within each locality and recommendations made on ways to improve and streamline the system.

RAPID HIV TESTS

- Advocate to regulatory authorities on the need for rapid tests (at health facilities and NGO sites) and the development of appropriate training on how to use the tests. Lobbying for the assessment of NGOs as VCT delivery sites is also needed.

TASK SHIFTING

- Develop a strategy for task-shifting specific to HCT, with recommendations on incentives and salary issues: in consultation with appropriate regulatory and legislative bodies, relevant faculty members and representatives of the health workforce.

RECOMMENDATIONS ON INCREASING UPTAKE OF VCT

- Expand methadone programs and increase their accessibility. Methadone programs have been demonstrated to be successful in engaging clients with other health services including uptake of VCT.
- Consult with police to encourage a reduction in harassment of clients (this has already proved successful in some sites in reducing harassment, stigma and discrimination). Reduction of harassment of clients near health facilities will likely improve acceptance and access to VCT, as well as other health services.

KYRGYZSTAN

In Kyrgyzstan, HCT is regulated by the 'Law of the Kyrgyz Republic on HIV/AIDS' August 13, 2005 No. 149, and is based on international standards. Specific regulations govern VCT. The Ministry of Health, Kyrgyzstan Order no. 445, December 11, 2007: 'Implementation of Voluntary Counseling and Testing (VCT) on HIV/AIDS in Medical Organizations'. [2][2] This order describes the role of the VCT specialist and defines the settings and levels at which personnel are required to provide VCT. Clinical protocols have been developed and disseminated to all health facilities involved in HCT. In the wake of a cluster of births of HIV positive children in Osh Oblast, The Ministry of Health also introduced an order in 2007 (No. 400) requiring the HIV testing of all pregnant women.

The provision of HIV/AIDS services is mandated at the Republican AIDS Center in Bishkek and at seven Oblast AIDS centers. These centers provide HIV testing and diagnostic facilities in addition to regulatory, surveillance and treatment services. They also are responsible for the training of personnel. Other health facilities involved in HCT are specialist services such as obstetric, dermatovenereological (STI), tuberculosis, infectious diseases, and narcological facilities, as well as family medicine centers (FMC), family group practice centers (FGP) and oblast, territorial and city hospitals.

Training in VCT has been provided since 1989 for selected staff at all health centers, including doctors and 'secondary medical workers', mainly nurses. Training in PICT was provided by UNDP from the early 1990s. Some heads of AIDS Centers believed their staff were well-equipped in HCT skills; others felt that further training was needed, especially for medical nurses who had only been trained in the basics. One center head said she did not feel confident that her primary health level staff could manage the workload – and suggested that a major focus should be training nurses to do this work, as well as training doctors.

Support for the provision of HIV and AIDS services has been provided from state budgets, and external donors such as USAID, the Global Fund for AIDS, TB and Malaria (GFATM), DFID and the Open Society Institute.

1.1 JALAL-ABAD

1.1.1 VCT AND PICT

1.1.1.1 HEALTH CARE INSTITUTIONS – GOVERNANCE/MANAGEMENT LEVEL

Several common themes emerged around the provision of VCT and PICT both in roundtable discussions and in individual interviews with heads of facilities.

- Workload and incentives

  All heads of services expressed the opinion that, while health staff were obliged under regulations to provide VCT and PICT, the heavy workload of physicians made it very difficult for them to provide adequate pre- and post-test counseling for HIV testing. Doctors in all of the services are only able to spend an average of ten to fifteen minutes with clients who they see in the health centers. They also usually spend half of the day making house calls. The salary of doctors who work in health facilities, which are not hospitals, is very low and it was stated on several occasions that incentives are needed for doctors to provide services such as adequate pre-test counseling and follow up of clients following testing.

[2] Study and Evaluation of Central Asia Health Facilities' Capacity in Provider –initiated HIV Testing and Counselling. Kyrgyzstan. Central Asia AID Control Project. 2005-2010. IDA and DfID

- Health worker attitudes and beliefs

  There were several references to the 'mentality' of the South where Jalal-Abad is situated. One director of an FMC stated: "Our direction is this, to work with sex workers, IDU and other vulnerable groups. But what we observe is that if FMC clients find that sex workers or drug users come to the center they [the other clients] won't come back, this is the dark side of our situation". At the same time there were beliefs expressed that health staff (doctors) were non-judgmental in their work with clients coming for VCT. There was acknowledgment on the part of some directors that theory and practice do not match.

  One director said physicians are very well informed about HCT and the need to target vulnerable populations in a concentrated epidemic, but he said that his staff do not have the skills to provide it. He added that another obstacle is that: "if we welcome clients [from vulnerable groups] openly, the villagers would never accept this".

1.1.1.2 HEALTH WORKERS

Health workers (mostly doctors and some nurses) from FMC and Family Group Practices, a smaller version of Family Medical Centers whose role is more as a general practice, were interviewed on their work in HCT.

- Pre- and post-test counseling

  The health workers reported all physicians are supposed to be skilled in providing VCT and PICT. They have had training, VCT manuals and protocols exist and it is a mandated part of their work. However, several doctors said in reality physicians are often not skilled, because at the primary health care level not all have received training due to a significant turnover of staff. In addition health workers are often nervous about asking questions on risk behaviors because they believe the client will become offended. Reporting of data on vulnerable groups is not conducted, even anonymously "because we do not discriminate," so no accurate data is available on the numbers of clients with risk-taking behavior.

  All the health workers said all pregnant women receive PICT, as this is mandated by regulations. Some health workers said their facility had a 100% testing rate for pregnant women, others disagreed that this was possible. The head of one AIDS Center (which provides laboratory testing and also pre- and post-test counseling) said they had a 90% return rate for people to come back for their test results. Follow up for clients who test HIV positive, is supposed to be carried out at the PHC level, but there is limited time for proactive follow up. For clients who test HIV negative, there is generally no follow up, and there did not seem to be a good understanding of the contribution this might make to HIV prevention.

  While VCT is mandated as a free service and several of the health centers said they provide this service free of charge, some health workers said: "everyone has to make informal payments in order to receive any type of service".

- Risk assessment and information provision

  For clients who attend for pre-test counseling for VCT, there is no standard risk assessment of specific risk behaviors. Each health worker conducts the level of assessment that s/he thinks is necessary. At one specialist center for women, it was said even for sex workers who have been referred from an NGO working with sex workers, the assessment comprised questions on: where the woman works, how many partners she has and whether she uses condoms. No specific questions about riskier sexual practices or drug and alcohol use are asked:

  "The woman will not answer, that's why we don't ask… she may get angry or leave. We can see that there has been anal sex but we don't discuss it".

  The main criterion for offering PICT seemed to be based on an assumption on the part of

the health worker, as to what an at-risk client might look like. In discussion, it seemed that most health workers believe they were too busy to offer PICT and expected the client to actively request VCT.

- In most instances, information provision appears to be limited to a written statement concerning the VCT procedure, which is handed out to the client. It was said this is a standard information form and is used throughout the health facilities. The client is given the form to read and if s/he has any questions the health worker will answer the questions. Otherwise the client signs the form agreeing to undertake the test. The form is only available in Russian and so does not meet the needs of low-literacy clients, or Kyrgyz or Uzbek-speaking clients who do not read Russian. Health workers said they refer clients to the appropriate friendly office (a stand-alone consultation room for sex workers with staff who should have been specially trained; there is only one in Jalal-Abad). They also said they had not seen any IDU or MSM.
- Confidentiality and psychosocial support

  Health workers maintained that they had been taught about, and respected the confidentiality of clients. Most stated they had no time for the provision of psychosocial support or counseling. Only the AIDS Center staff had time allocated to this.

1.1.1.3 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS - IDU

NGOs estimate that there are approximately 2000-3000 injecting drug users in the Southern region of Kyrgyzstan, 80-90% of who are estimated to be male. One NGO said the numbers had diminished because of a police crackdown on several hotspots that has “forced them out”. Some drug users have been incarcerated and it is also likely that many have been driven further underground to various parts of the region.

- Access to services

  One NGO and its clients were visited during the course of the technical assistance. Prior to support from the Global Fund, USAID and DFID-funded projects, NGO support for drug users in this region was fragile. Now there is a solid base of collaboration between the NGO and selected health services, due in large part to the advocacy work of the NGO members. There are some constraints within this system. Firstly the NGO works with only a few preferred facilities, where good relationships have been established. According to the NGO and the clients, these facilities show respect, maintain confidentiality and do not stigmatize or discriminate against IDU. Clients of the NGO can gain access to a wide range of services, although many of these, just as for other members of the population, must be paid for. For example, dental services and X-rays. However, when clients want to go for VCT, they must attend the AIDS center where they say the staff are quite limited in number, and confidentiality is not protected because there is no designated room for counseling. Clients who do not have access to this NGO are not able to receive the same level of support that has been developed through the NGO. Likewise, health facilities that have not been involved in the sort of capacity-building exercise that has taken place through previous projects, are reported not to have the same level of ‘user-friendliness’ or skill in dealing with client-specific needs. Even in ‘friendly’ services the quality of care varies – complaints were made by clients about the inability of some nurses and doctors at the AIDS Center to find a vein to take blood from IDU. In other health facilities, clients stated they were humiliated and treated badly by health workers:

  “They close mental doors – I would rather stay at home than go to a clinic or a hospital for anything.”
- Referrals

  Clients usually come to the NGO drop-in center for advice before going to a clinic or

hospital. The NGO visited, had staff trained in VCT. But because the regulations do not allow people other than health workers in facilities to provide VCT, and there are no rapid tests available, the NGO refers its clients to the AIDS center, with a referral form and accompanied by an NGO staff member: a system the NGO calls 'social management'. It was said nearly 100% of clients return for their first test result. There is an agreement that if the first test is positive the AIDS center requests the NGO to re-refer the client for a second test. Often clients disappear and NGO workers put effort into vigorously following up missing clients. There are no specialized services for female IDU, although about a third of NGO clients are women (currently seven women and twenty men are active members of the NGO). The NGO advises all HIV negative clients to return for testing every three months.

1.1.1.4 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS – SEX WORKERS

The NGO and focus group visited, estimated that they have seen 631 female sex workers since 2010. The NGO staff and members said they did not know of any male sex workers in their area. They have developed a drop-in center that has well-established links with Osh and other places in the region, and provide a range of health services.

- HCT

  As is the case with other NGOs, this NGO cannot provide HIV testing as there are no rapid test kits available, staff have not been trained and only health facilities are mandated to provide VCT. They provide considerable discussion, pre-counseling and psychosocial support for clients in preparation for testing. Of the 631 sex workers that have been involved in the NGO, 307 have attended for counseling and received test results at the friendly office in the Reproductive Health Center.

- Referrals

  Clients are referred to the friendly office. A referral form is used and clients are accompanied. Clients said they had no complaints about the services, although a comment was made that administration staff at the Oblast AIDS Center are not very friendly, but that the frontline workers were 'good'. Although the NGO reported that an insignificant number of sex workers used drug, the NGO will refer sex workers who use drugs to the IDU NGO for support, while still assisting the sex workers with access to the friendly office at the Reproductive Health Center for HIV counseling and testing.

1.1.1.5 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS - MSM

There were no NGOs for MSM known to either the health services or NGOs in Jalal - Abad.

1.1.1.6 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS - PLHIV

All four members of this focus group were ex-IDU. They spoke about their shock at finding out about having HIV. Each one had since stopped using drugs or was on a methadone program. They described their experience of attending counseling and testing as "frightening and triggering anxiety". One of the four focus group members said at one time he was able to go to the AIDS center free of charge, and that this was why he went to be tested for HIV:

"Now if you have a health problem or want to go for a test, you must go to the polyclinic and pay a co-payment".

All of the group agreed that support offered by the NGO was paramount in helping them to go for counseling and testing, and that the pre-counseling work done by staff members was very important in helping to prepare them for a positive test result.

Several members believed targeted interventions are needed to educate and work with the families of vulnerable groups and PLHIV.

1.2 OSH OBLAST – KARA-SUU RAYON

1.2.1 VCT AND PICT

1.2.1.1 HEALTH CARE INSTITUTIONS – GOVERNANCE /MANAGEMENT LEVEL

Osh Oblast has the highest number of people with HIV in Kyrgyzstan, approximately half of PLHIV live in the region, and there are between ten to fifteen new infections each month among pregnant women. The Oblast has defined priority groups for HCT as being: pregnant women, IDU and sex workers. Kara–Suu Rayon is the biggest rayon in Osh Oblast with seven FMCs, governing 76 primary health clinics and 26 FGPs. There is only one FMC for the city of Kara-Suu.

- Workload and incentives

  Family practitioners in Kara-Suu on average see about thirty clients per day. There is little office space and doctors rotate through offices. When they finish a shift they go to work at the dispensary level facilities and their office at the FMC, is occupied by another doctor. There is no office space for confidential counseling. It was said there is little time for follow up of clients at the dispensary or FMC level. One head of a facility admitted that there was a problem with staff expecting clients to pay for services, although she added: ”of course we will take them [if they have no ID and/or cannot pay], we will not send them away”.

- Capacity to perform HCT and referral

  It was said facilities at all levels have the capacity to conduct anonymous HCT, although lack of space was an issue. In addition to the outpatient facilities there were also three hospitals that provide HCT. Clients are given pre-test counseling at the FMC, FGP or by a primary health practitioner. Blood samples are sent to the Oblast AIDS Center, then the blood test result is sent back to the physician, who has requested the test and they are the ones to inform the client of the test result. Clients can also go to their own primary physician for pre-test counseling and referral for blood collection. These clients are also referred back to the FMC to receive their test results and the family physician at the dispensary level is required to follow up HIV positive clients. Thus the client whose HIV test is positive, must see at least two different practitioners, but clients who test HIV negative do not receive any further counseling. It was asserted that all basic HIV services including HCT are free, even if the person does not have an Identification card. If the client attends with a referral form from an NGO, s/he is guaranteed free service. In the Oblast AIDS Center there is a separate pre- and post-test counseling room. One director acknowledged the complexity for clients navigating the system and said she had been thinking of a ‘one-stop shop’ model, where clients could have all services delivered under the same roof.

- Collaboration with NGOs

  The Director of the FMC visited, said the facility has a good relationship with many of the organizations working in Kara-Suu. In particular the NGO working with sex workers has developed a close working relationship with the FMC. Some IDU attend the center independently, whereas sex workers are generally accompanied. NGOs are informed of the quieter times for clients to be seen (in the late afternoon) and usually bring their clients after 3 pm. The Director of the Oblast AIDS Center added that the AIDS center had a very close collaboration with NGOs.

1.2.1.2 HEALTH WORKERS

The discussion commenced with a reminder from the Director of the Oblast AIDS Center that current instructions from the Ministry of Health identify the need to improve the provision of

primary health care to vulnerable groups and review the current status of VCT, among other directives on primary health care strengthening (PHCS) such as the integration of HIV and TB into primary health care.

- Workload

  There were many comments on the heavy workload of doctors, who are expected to provide HCT, in addition to their clinic work. A suggestion was made that if high-quality pre- and post-test counseling is to occur, an HIV specialist post needs to be created, as primary health physicians do not have the time to provide appropriate counseling. Another participant noted that according to the regulations, all primary health physicians are mandated to provide pre- and post-test counseling and many have received the training. A severe lack of space for counseling was cited as another reason why physicians could not provide counseling, or adhere to the need for confidentiality. It was acknowledged that there were no offices for counseling, as most doctors share offices already.

- Capacity to perform HCT and referral

  One participant said at all the FMCs in Osh Oblast there was a designated specialist responsible for all HIV patients. They added that one person cannot cover all the vulnerable groups and that if the specialist sees patients from vulnerable groups, then other clients won't attend her/his clinic because of stigma. Another participant suggested that there should not be a single specialist, but that all staff should have the skills to provide HCT. Only having one specialist automatically affects confidentiality, because everyone sees the client with that specialist, and that furthermore the client has the right to choose which doctor s/he would like to see. All agreed that pre- and post-test counseling should be provided, but that in reality it does not happen. For most clients who attend for counseling, there is provision of an information and consent form, which includes some explanation of the test, but counseling does not take place. Another reason given for clients from MARP non-attendance was the requirement for registration. Migrants, and IDU in particular, are discouraged by this because they often have no ID papers.

  Participants agreed that skills in the provision of HCT required more than just 'knowledge' and that health workers need to be trained in advanced communication skills: enabling them to address difficult, embarrassing, taboo topics with clients, including taking a full risk assessment. Such a training could contribute towards upgrading staff's medical education.

- Social Management

  Several health workers said without the escort of an NGO staff member, the majority of clients from vulnerable groups would be lost to follow up and that physicians do not have time for patient follow up. Some participants said that even when people are accompanied by NGO staff, there are often people who test HIV positive on the first blood test, who do not return for a second test. Another participant bluntly said if a person attends for VCT and does not return for the second test, the physicians "forget about them then, because they've been handed over to the AIDS center".

- Stigma and discrimination

  Health workers acknowledged that: "no-one likes drug users". The clients have to wait in queues and may be exposed to ridicule by other clients or by health workers: "we need to change the psychology of physicians". Without an escort, a client from a vulnerable group was less likely to wait in line or to be treated with courtesy. No participant mentioned MSM as a vulnerable group. One participant said that she had heard about MSM, but had not met any in the course of her work.

1.2.1.3 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS – IDU

- Fear of attending clinics and hospitals

  Many clients spoke about their fear of going to clinics or hospitals, even with a referral form, as they had had experiences of being treated badly by health workers. They also said police who routinely target them because of their appearance, when they are in the vicinity of clinics or hospitals victimize them. Blackmail or beatings for no reason are common. Subsequently, they only go to clinics or hospitals when it is urgent.

  With regard to HCT the clients said they do not self-refer. They go to the IDU NGO, obtain a referral form and are accompanied by a staff member (who is a volunteer in this organization). In this way they receive free treatment and it is of a better quality. Several clients said the hospital administrative staff are rude, but that the medical nurses treat them well. Most clients said they have been reluctant to go for HCT, but tended to focus on the perceived ill treatment they might receive, rather than fear of the test result. There were suggestions from several of the group that there should be more mass media to educate the general public against stigmatizing and discriminating against IDU and other vulnerable groups.

- Desire for rapid tests

  Both clients and NGO staff expressed the belief that there was a need for rapid HIV test kits to be made available, so that NGO staff could be trained to provide the first test. Even though clients who had a positive rapid test result would need to be followed up at the AIDS center, clients and staff thought that having rapid testing available at the NGO, would encourage more IDU to come forward for testing. This would enable the NGO to engage clients in follow up testing and into care and treatment.

- Social Management

  Escorting clients to clinics is currently a service provided by volunteers (peer workers, also referred to as social workers). It is time-consuming and transport can be costly, for the client and escort. NGO staff and clients expressed a desire for substantial training (in all aspects of HIV and harm reduction) and a salary for the peer workers. The referral form that was used by this organization was specific to its own needs and was developed out of an agreement with the FMC and Oblast AIDS Center, for the provision of free services. If the client is not associated with an NGO and not escorted to services, s/he must pay for services.

1.2.1.4 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS – MSM

The participants involved in this meeting, consisted of staff and members of a small organization of MSM.

- Fear of disclosure

  The main concern for all participants was fear of disclosure, of their homosexual or bisexual status. One participant said because homosexuality is illegal in Kyrgyzstan (this law was repealed in 1998 and homosexuality is no longer illegal), even coming to meet his friends in this club was a dangerous activity. No-one in the group had disclosed his status, most were married and had children, stating that they had been pressured into getting married by family:

  “if you reach thirty and are not married, people start to tell your family there is something wrong with you”.

  The participants said Osh was a deeply conservative region of the country and that it would not be possible to disclose their status to a health worker, during VCT because of concerns about confidentiality. Consequently they do not attend public health facilities, but use the

services of a “friendly” physician, who they trust and who sees all members of the group. No participant in the group said they had attended for HCT.

1.2.1.5 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS – PLHIV

The participants spoke about their experiences of finding out that they were HIV positive and how this knowledge had affected their lives.

- Experience of counseling and testing

  One participant said he had been very shocked to find out that he was HIV+, he had been an IDU and since finding out about his status had decided to stop using drugs and join with his peers for mutual support. He had joined this NGO and now was employed by them. He contributes to the work of the NGO, by sharing his experiences with IDU who are not aware of the risks of becoming HIV positive.

  Some participants said pre-test counseling had taken place, but that it had been of no use at the time and that it had been the support of their peers that helped people to come to terms with the idea of being HIV positive. Another participant said on receiving the news of being HIV positive, he had gone back to his old lifestyle and that it was members of the NGO who had brought him back from that life to sobriety.

  One client of the NGO suggested that the health structures were not properly informed about HIV and that if they were, “they would not behave so badly” towards people with a positive status. Recommendations from participants were that health staff, both doctors and nurses, need better training to provide pre- and post-test counseling and in taking blood samples. Further recommendations were that some of the responsibility (along with appropriate training) for pre- and post-test counseling, blood taking and performing rapid HIV tests, should be handed over to NGOs because “the medical workers say that they don’t have the competence to do it”.

1.3 BISHKEK

1.3.1 VCT AND PICT

1.3.1.1 HEALTH CARE INSTITUTIONS – GOVERNANCE /MANAGEMENT LEVEL

Participants shared their thoughts on constraints in the current system and how these affect their ability to provide quality HCT.

- Workload, recruitment and retention of staff

  One director of an FMC said since the establishment of FGPs in 1996, there had been attempts to develop the role of a family medical practitioner, but that in reality the roles were still very specialized at the primary health center level. This meant that physicians continued to work in the ways they had always worked, and had not developed appropriate skills to work with MARPs. Young doctors did not stay long at the primary health center level, but moved to more profitable positions in hospitals.

  The average workload of a doctor was six hours consulting in the clinic and two hours on home visits. Most doctors take medical notes home to write them up, as they have no time during their working day.

- Training in the provision of, and access to VCT and PICT

  With staff turnover levels high, there was a constant need for re-training. While most staff (doctors and nurses) had had training in VCT two years ago, there was a need to provide refresher and first-time trainings. Health workers usually “ask some questions” if they suspect a client may be HIV positive. There is no standard risk assessment. At the FMC level, clients who attend and request VCT are provided with an information sheet and are

asked to sign a consent form, after which blood is taken and sent to the AIDS Center for analysis. One participant said the health workers needed training in PICT specifically: “most staff refer patients to the AIDS center if they suspect HIV” because they do not feel confident in PICT and have not had training.

The Narcology center had allocated funds for rapid HIV tests and training for staff as part of a plan to provide the full range of HCT and services at the one facility. The director said up until now, VCT had been aimed at the general public and that education and awareness-raising has not reached vulnerable groups, with only 2,000 IDU having been tested out of an estimated population of 25,000-30,000.

- Perceived attitudes of health workers

  One head of a health center offered the opinion that most health workers are unwilling to work with IDU at the primary health center level: “…IDU are equated to animals and that’s the problem we have, because of the mentality here”.

  The director of the narcology center said although IDU clients are provided with pre-test counseling, they often do not attend the AIDS center for testing, because of their fear of stigma and discrimination from other clients and from health workers.

1.3.1.2 HEALTH WORKERS

- Opinions of health workers on VCT provision

  Participants supported the current VCT system, where clients must go to both the primary health center and AIDS center, stating that NGOs should not be involved in VCT: “Even if the physician is overloaded, we should maintain the two-tier approach to VCT”.

  Many participants said there should be salary increases to compensate for the extra workload as a result of providing VCT. ‘Friendly physicians’ (in this instance this referred to physicians working in a specific donor-funded project) were adequately remunerated, but other physicians were not but were still expected to provide the same level of service. All participants were in agreement that there was not enough time to spend with clients in counseling.

  One participant said that there was not a successful collaboration between health facilities and NGOs in all parts of the city and this caused tensions when the issue of VCT was discussed.

- Training in, provision of and access to VCT and PICT

  Training in VCT was provided in 2005 for specialists and non-medical staff. Since that time participants said the situation has changed due to a loss of staff and an acute lack of funding for governmental institutions.

  There was consensus among participants that coverage of VCT is low, but at the same time several health workers felt strongly that the provision of VCT was the role of the health worker and should not be expanded to NGOs: “ they cannot provide counseling”.

  One participant made the point that for many clients the process of VCT starts in prison where they are coerced into HIV testing. There is a lack of voluntary opting-in and a systematic threatening of clients to be tested. The quality of knowledge and skills in HIV counseling among prison staff is low and many clients are released with no knowledge of what to do after release.

  A comment was made that, while there are standards for VCT, there is no effective monitoring and evaluation of the quality of VCT.

1.3.1.3 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS– IDU

The NGO visited worked in harm reduction in several facilities – they work with the Narcology center in the methadone program, to support clients with mental health issues and with clients in the detoxification center and engage in awareness-raising on the dangers of polydrug use. They refer clients to a range of services including gynecological services and they have several women clients but no other services for women IDU exist.

- Access to VCT

  Participants said they work with the City AIDS Center and STI Center to provide HIV testing. Clients are able to gain access to VCT at these locations without documentation. Clients said they were happy with the quality of service provided. It was said if a client goes to the FMC there is always a co-payment expected, even though the service is defined as free. Another participant said that: “if you go to the FMC you are kicked from pillar to post”.

1.3.1.4 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS – SEX WORKERS

Clients and NGO managers described the activities of the group. The NGO visited has been in existence since 1997. They now have a range of services including activities on HIV prevention; outreach, counseling on sexual health issues, reproductive health and HIV; legal services; a drop-in center and escorts for clients to health facilities.

- Provision of counseling and testing for VCT

  One of the main activities of the outreach workers is to provide preparatory counseling to encourage clients to attend for VCT. This preparatory counseling usually takes place where the women work, in the street or at the place where their work is located.

  Many clients have experienced coercion in the past from the morality police (which no longer exists) forcing sex workers to go for HIV testing and extorting money. NGO staff said a significant amount of encouragement is required. Even so clients still face stigma from some of the physicians at the friendly offices based in some of the health centers.

  The NGO staff expressed the desire to be trained in rapid testing and to be equipped with rapid test kits. Their aim is to train a specialist to offer pre- and post-test counseling.

- Barriers to the voluntary uptake of HCT

  The staff said the quality of service depends on the personal characteristics of the physician. Many health workers have a discriminatory attitude to sex workers, and always expect a payment for free services. They distrusted health workers and assumed they would disclose a person’s positive HIV status.

  Pregnant women are often coerced into testing for HIV. They are provided with a form that contains medical jargon or abbreviations that they do not understand and are told to sign the form. No counseling is given. Information on prevention of mother to child transmission of HIV is also not given.

  Consequently, the NGO has spent many years working to establish a close working collaboration with specific health services. The NGO has chosen one FMC and maternity hospital, to which they accompany their clients and will avoid taking them to other FMCs.

1.3.1.5 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS – MSM

Participants in the discussion explained that while it was easier to maintain anonymity in Bishkek, the members of the NGO still only meet in their office, although they do organize

events at the few gay clubs that exist in Bishkek. The group members spoke about issues relating to disclosure of their sexuality, legal concerns and health care needs.

- Access to and quality of HCT

  This NGO has its own website and many clients gain information from that website on how to contact its outreach workers. The NGO has established collaboration with a clinic that has a 'friendly physician' who provides clinical services, mostly for STIs. One participant said what's needed is to train a few physicians from selected FMCs on the needs of LGBT clients. Another participant made the point that if clients are better off or are in couples, that they can pay for private health services and receive a much better standard of care. Some clients also attend the AIDS center; members would prefer to go to the STI center: where there are friendly physicians but that means waiting a week for a test. The NGO has an agreement with the STI center and this provides good quality services to their clients. PICT is practiced at the STI center. One participant said at other FMCs, even if a client attends with symptoms, no HCT is offered, no risk assessment is conducted and the need for VCT is mostly dependent on the physician's perceptions.

  The NGO conducts considerable awareness-raising activities for VCT. They emphasize the importance of using condoms and the need for regular testing: "Some clients even call to say it's three months, time for a test".

  Participants noted that the quality of pre- and post-test counseling was paramount to the client's acceptance of the result. Sometimes the person disappears before the second test is due, at other times the client is in a state of shock. One participant said the quality of pre-test counseling was variable and sometimes insensitive, including insensitive questions about anal sex. He felt that by the time the person went for testing, he should have received enough preparation by his peers that the health facility counseling should be more of an informed consent discussion.

1.3.2 HEALTH SYSTEM ISSUES

1.3.2.1 COLLABORATION BETWEEN FACILITIES

One director of an FMC said that a major concern was that because the AIDS centers had become specialist centers, there was no connection between them and the other health facilities such as the FMC and FGP. Data on clients is kept at the AIDS center and is not shared appropriately with the FMC or FGP, which are supposed to provide follow up care for clients. There seemed to be a lack of quality assurance across health centers: although standards for VCT had been disseminated, no monitoring and evaluation of the quality of services was undertaken.

1.3.2.2 STAFF RECRUITMENT

Directors of services said they were limited in their ability to recruit extra staff by the proscribed staffing list of the center, although one director interviewed said that he had reorganized his staffing list to include an HIV and AIDS specialist position. Some FMCs said it was hard to recruit and retain staff at the FMC or FGP level, because the salary was lower than in a hospital. To stay at a primary health center, people have to be very committed to the work and the younger doctors usually move to higher paid facilities.

1.3.2.3 STAFF WORKLOAD

Managing the workload of doctors in a system that has yet to evolve into a primary health care model is very difficult. Clients receive the bulk of their care at very busy, very large, outpatient polyclinics (which have been renamed family medicine centers) and doctors spend half of their day making home visits. Nursing staff seem to play a fairly passive role:

although some also conduct home visits. A discussion about possibilities of task shifting, e.g. creating a cadre of community nurses to conduct home visits was not well received. Doctors who perform home visits receive 'informal' payments that supplement their incomes.

- Regulatory framework

  Family medicine group practices are governed by the FMC – they do not have the authority to make changes to current structures. This includes changing workload structures, the management of community visits and the possible development of different models of HCT, such as mobile VCT or home-based VCT for difficult-to-access populations.

1.3.2.4 REFERRAL SYSTEM

The mechanisms for referring clients vary, they may be sent to several places in the course of trying to obtain HCT. Primary health centers refer to higher level facilities, that carry out laboratory testing and these then refer back to primary health level for follow up. The multiple level system risks loss to follow up, a potential lack of adequate preparation and post-test counseling and can jeopardize confidentiality, especially in smaller centers and towns.

NGOs working with MARP clients choose their preferred centers for referral. They've developed a system where they accompany clients to their health visits (social management) and the use of a referral form that seems to guarantee a free service (for a service that is already mandated to be free throughout the country). This form often only seems to work if an NGO staff member has accompanied the client. Each NGO has developed its own referral form, sometimes as a part of a previous donor-funded project. There is no standardized form currently in use. While easier access to services for MARPs is paramount, there is the potential for this referral system to be seen as a right to preferential treatment by clients of NGOs, some of whom already feel that they should not have to wait in queues to see health workers, although queuing to see medical practitioners is the current reality for all members of the population.

1.3.2.5 COLLABORATIONS BETWEEN NGOS AND HEALTH FACILITIES

- Achievements

  Many NGOs have worked hard to establish close relationships with health facilities that provide non-discriminatory services for their clients, resulting in a streamlined system for referral and better quality of services than may be found in other centers. Health workers at those facilities have mostly developed a better understanding of the needs of specific MARPs.

- Disadvantages

  Many of the collaborations are based on a relationship with one or two specialists at the health facilities, not necessarily with all of the health workers. The quality of service is highly dependent on these individuals, rather than on a system-wide improvement in quality of care. Clients, who are not members of an NGO, may have no access to the same level of service.

1.3.2.6 RAPID TESTING

- Many NGOs expressed the desire to have rapid tests freely available for NGO staff to use. In order to overcome the need to go to a health facility and to provide the first test in an environment that was more supportive for clients.

1.3.2.7 MATERIAL RESOURCES

- Supplies for occupational health and safety

The supply of gloves and other protective equipment such as goggles (for delivery suites) is often interrupted. This can be due to insufficient budgets or to stock-outs.

- Literature

  Literature for clients about VCT and other aspects of HIV is in Russian. Clients who read only Kyrgyz or Uzbek have no access to information material. Likewise, staff have no access to manuals and protocols in their own languages and manuals that are written in Russian are often lengthy and complex. There are very few low-literacy materials available.

- Office space

  Most facilities were overburdened. There was a lack of office space and separate rooms for counseling in the general clinic setting.

1.4 RECOMMENDATIONS

1.4.1 PRIORITY RECOMMENDATIONS FOR HCT IN LOCALITIES

TRAINING

- The most important aspect of training for health staff is to develop skills in communicating effectively with clients, especially on sensitive issues. Develop a short course combining: experiential learning on basic communication skills; skills specific to VCT and PICT (including conducting a risk assessment and counseling for a negative result); and on reduction of stigma and discrimination. Roll out the training to frontline workers at trust points, friendly offices, FMC, FGP and at dispensary level (where dispensaries exist in the entry point localities). Tailor the stigma and discrimination component of the training to the relevant locality, for example, in the south of Kyrgyzstan, stigma and discrimination against MSM and migrants is intense and would require specific address. Involve the relevant postgraduate medical education institution in this process.
- Develop training in communication skills for nurses. Roll it out to nurses in trust points, friendly offices, FMC FGP and at the dispensary level.

QUALITY ASSURANCE AND SUPERVISION

- Develop a system of mentoring and clinical (supportive) supervision for doctors involved in HCT, in collaboration with the relevant postgraduate medical education institution and a number of senior staff from health facilities. Roll out the training to a number of health facilities in Quality Project localities. The aim being to expand this supervisory system to all health facilities and to include nurses, within the localities in Year 2.
- Develop a standardized risk assessment pro-forma, in consultation with representatives of health services and NGO staff and clients. Health workers, who have undergone training in communication skills, should receive additional training on the use of the risk assessment.
- Develop a monitoring and evaluation system focusing on the quality of HCT, based on qualitative indicators and include the contribution of NGOs and health workers.
- Develop a post-training evaluation (to be conducted 3 months after the training) for clinicians who have received training in communication skills (as described above).

REVIEW OF REFERRAL SYSTEMS

- Thoroughly review referral systems, including individual NGOs' referral forms, and the current practice of escorting clients to clinics in Year 1 and continue into Year 2. It should be

conducted, in collaboration with NGO staff, within each locality and recommendations made on ways to improve and streamline the system.

1.4.2 RECOMMENDATIONS FOR HCT IN PROJECT YEAR 2

RAPID HIV TESTS

- Advocate to regulatory authorities on the need for rapid tests (at health facilities and NGO sites) and the development of appropriate training on how to use the tests. Lobbying for the assessment of NGOs as VCT delivery sites is also needed.

TASK SHIFTING

- Develop a strategy for task-shifting specific to HCT, with recommendations on incentives and salary issues: in consultation with appropriate regulatory and legislative bodies, relevant faculty members and representatives of the health workforce.

QUALITY ASSURANCE AND SUPERVISION

- Expand the system of mentoring and clinical (supportive) supervision for doctors involved in VCT to all other localities. Include the mentoring and clinical supervision of nurses in facilities in the localities, as part of a larger strategy of task shifting of roles.
- Collaborate with representatives of health services and NGOs to define and then implement quality services (such as partnership-defined quality).

TRAINING

- Develop a refresher training on communication skills (as described in Year 1) to deliver to frontline workers (doctors and nurses) currently involved in HCT at trust points, friendly offices, FMC, FGP and at dispensary level.
- Consult with the appropriate regulatory body for medical and nursing education, to discuss the development of pre-service trainings for doctors and nurses in HCT and communication skills.
- Write a curriculum on HCT that includes: addressing stigma and discrimination (especially in relation to most-at-risk populations), and teaches communication skills. Curriculum to be developed in consultation with the appropriate health faculty for pre-service education for doctors and nurses.
- Translate material resources – client informational materials, HCT training materials, clinical guidelines and protocols and medical handbooks into Kyrgyz (and additionally into Uzbek in the south of Kyrgyzstan). Low-literacy materials for client information and education should be produced with Kyrgyz and Uzbek relevance.

RECOMMENDATIONS ON INCREASING UPTAKE OF VCT

- Expand methadone programs and increase their accessibility. Methadone programs have been demonstrated to be successful in engaging clients with other health services including uptake of VCT.
- Consult with police to encourage a reduction in harassment of clients (this has already proved successful in some sites). Reduction of harassment of clients near health facilities will likely improve acceptance and access to VCT, as well as other health services

KAZAKHSTAN

HCT is regulated in Kazakhstan by provisions in the Code of the Republic of Kazakhstan 'Health of the people and the public health system', No. 193-IV 3RK which came into existence on September 18th 2009. According to this health code, HIV testing is conducted free of charge.[3]

Facilities mandated to provide services include the Republican and City AIDS Prevention and Control Centers; rooms for anonymous HIV testing and psychosocial counseling in medical facilities such as outpatient clinics; clinical diagnostic hospitals, students' outpatient clinics, family doctor outpatient clinics and specialist centers such as TB facilities, narcological and dermatovenereological centers and dispensaries. There are 168 trust points and 31 friendly rooms in Kazakhstan. Seventeen trust points for clients with STIs or IDU and eight friendly rooms for sex workers and MSM are based in Almaty. NGOs provide a wide range of services to the most-at risk populations – IDU, MSM, sex workers and PLHA.[1]

2.1 ALMATY

1.1.2 VCT AND PICT

1.1.2.1 HEALTH CARE INSTITUTIONS – GOVERNANCE/MANAGEMENT LEVEL

Fourteen senior management and clinical health workers from government organizations and one representative from an international NGO attended a roundtable meeting on VCT, PICT and models of HCT.

- Access to VCT

  Health directors said the system in place in Almaty assured confidentiality. Signage inside the outpatient clinics directed clients to a separate friendly room in which designated staff provided anonymous counseling and blood collection for HIV testing. Clients are not required to provide their identification. Counseling involved a series of questions, regarding the reason for attendance and discussion of some aspects of risk, such as sexual activity and injecting drug use, although there were no standard risk assessment questionnaires. Forms used to collect information were focused mainly on demographic data.

  There are 8 friendly rooms (specifically for sex workers and MSM) in Almaty City. There are a total of 40 designated separate rooms for anonymous counseling in the specialist outpatient clinics. Each outpatient clinic has one doctor assigned from the City AIDS Center responsible for the HCT system. This doctor also supervises district physicians. A comment was made that district physicians "are not interested" in identifying MARPs because they already know the clients.

  The director of the City AIDS Center said they had already instituted a mobile system for VCT – a minibus conducts twice-weekly visits to sex workers and provides rapid HIV tests, educational materials and condoms. The AIDS Center has also established a good working relationship with the police (through interagency consultations with the mayor of the city).

  A director of an outpatient clinic said all VCT was free and anonymous, as directed by 'State Code 14'. However, she added that in order for enough VCT to be provided to target MARPs, extra funding would be required to: pay for staff to work in the friendly offices, for outreach workers, for more equipment and for separate rooms for counseling. She said virtually all clients who attend for pre-test counseling decide to take up VCT and everyone returns for their post-test results.

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[3] Study and Evaluation of Central Asia Health Facilities' Capacity in Provider –initiated HIV Testing and Counseling. Kazakhstan. Central Asia AID Control Project. 2005-2010. IDA and DFID

Trust points for IDU and their partners have a dedicated telephone number and are constantly staffed by a nurse. It was acknowledged by some members of the group that some outpatient clinics were 'stronger' than others in providing a service according to recommended standards. Thirty outreach workers liaise with the trust points to engage with IDU in hotspots around the city, to encourage testing, to provide education, and to encourage clients to use needle-syringe programs. There were plans to have a mobile service (like for sex workers) but no funding for this has been available.

Until this year, migrants were able to gain access to VCT. Now this is not available in the city and private clinics provide testing, but no counseling is offered. If migrants want to obtain permanent residence they must undergo HIV testing.

With recent mooted changes in the criminal law, there are likely to be between 17,000 and 20,000 prisoners released from jail this year. Some of these may have been coerced into testing while in jail, but many of them won't know their HIV status. Prisons are known to have high levels of needle sharing, unprotected sex and sexual abuse. There seemed to be no strategic plan for dealing with an influx of potential HIV positive clients re-entering the community.

- Training

  VCT training began twenty years ago in Kazakhstan. In at least one outpatient clinic VCT training has been provided during the last year (2010) for all medical staff. There has been consistent effort to extend the roles and responsibilities of nurses. Nurses have received additional training and incentives to work in HCT. The designated HIV medical specialist supervises them. Nursing staff complete registrations, collect all data, perform the initial assessment and provide counseling. Nurses also liaise with outreach workers from the various NGOs.

  Training in PICT was not mentioned, nor was there discussion of its practice by health workers. The focus of both health institution heads and health workers, was on compliance with the 'Order on the Provision of VCT''.

- Requirements for populations to be tested

  State regulations require HIV testing for blood donation and for all pregnant women. Surgeons, both public and private, also require everyone who needs surgery to undergo HIV testing. 'Regulatory Order No 552' recommends that all IDU should be tested twice yearly for HIV.

1.1.2.2 HEALTH WORKERS

- Provision and quality of VCT and PICT

  Health workers said their workload for other medical services was high and their salaries were low, and that there was little time to provide the intensive support required for pre- and post-test counseling. They felt there was a lack of motivation on the part of some health workers and a passive approach to VCT was taken: if people came for VCT they would take a history and be referred to the trust points or friendly office. In one outpatient clinic that was visited, the friendly office was a locked room that was only opened when clients requested VCT. The gynecologist responsible for this service, said she only usually saw about two clients a month and that she did this work on a voluntary basis. She said she felt compelled to do this because no one of her colleagues were interested. She had received two days training in 2010 at the City AIDS Center.

  PICT was not actively practiced in clinic consultations with clients who may be at risk, except in the case of the City AIDS Center, which had commenced a mobile VCT service. The most common approach to HCT was to wait for a client to request it. The physician would then

ask some basic questions, send the client to another room to register and refer them to a friendly office or trust point.

Participants in a health worker focus group, said ‘State Order No. 552’ gave guidelines as to which VCT should be offered, but there was little acknowledgement by those being interviewed on the need for quality assurance. Supervisors exist for the friendly rooms and trust points but seem to play more of an administrative role. Participants focused on the regulatory aspect of the provision of VCT:

“We work in accordance with the order – whatever the order says – we do”.

- Mental health needs of clients

Several participants in focus group discussions recognized the need for health workers to develop skills in dealing with clients’ mental health needs, during pre-test counseling and following a positive HIV result. They described clients’ reactions that ranged from: alarm, aggression (both to self and others) and sometimes suicide. A comment was made that there was insufficient post-test counseling and that there were not enough specialists in mental health issues. There are very few psychologists in the country. Physicians must deal with all social and psychological issues and rarely have time to provide the post-test counseling and follow-up that is needed. Several participants said IDU require extra support from health workers. Workshops and seminars have been provided for health workers to address issues around risk factors and working with most-at-risk populations

Most-at-risk populations

Participants from institutions (other than the one, which provides mobile and outreach workers to MARPs) said they did not see many clients who are sex workers or IDU. One obstetrician at a large outpatient clinic said her service only sees a small number of sex workers, and does not have a routine risk assessment protocol. This may be due to the preference of sex workers to go to other clinics that have developed sex worker-specific approaches. trust points were the favored point of entry for IDU. “IDU are spread out and hidden”.

- Referral and follow-up of clients

With the exception of the AIDS center that provided outreach and a mobile unit for sex workers, trust points and friendly offices mainly responded to self–referrals by clients. One trust point in an outpatient clinic said they saw at least fifteen clients each week. However, examination of the registration book showed there had only been 16 client attendances in the last quarter. This same clinic, once had a friendly office for sex workers, but this seemed no longer to exist.

Clients gain access to VCT in two ways: they either attend an outpatient consultation with a specialist, and are then referred to a friendly office or trust point; or they directly go to the friendly office/trust point. Bloods are sent to the City AIDS Center and the client returns in a week to the same office for test results.

Clients may or may not be accompanied by members of an NGO, this depends largely on which NGO they are associated with. There is no voucher system used; although there is a USAID-funded voucher system that has been set up but it is not used by any of the health centers or NGOs presumably because of the distrust that exists between NGOs and health centers.

1.1.2.3 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS – IDU

- Access to VCT

Access to VCT varies according to which NGO a client is associated with. One NGO preferred to send clients directly to the City AIDS Center. Another NGO had developed a

collaboration with an outpatient clinic, but would not send clients to other clinics. Participants agreed that VCT was supposed to be free and anonymous, but the reality was that if a client asked for a free service s/he was generally treated badly, whereas if clients paid they would be treated well.

All participants said if they go for an HIV test and the result is negative, then there is no follow up offered and there is also no access to any of the other medical services they might need, which are available for PLHIV.

- Referral

  Most clients approach an NGO to discuss their concerns about HCT, before attending a health facility. NGO staff would provide pre-counseling and information, and then refer them to the preferred center for that NGO.

  Some NGOs had tried to use a voucher system but felt this made no difference to the service. They said clients only receive a good service if they paid: “nobody wants to accept the voucher system”. Clients generally were not accompanied to centers.

  One NGO staff member said out of 507 clients sent to the AIDS center (since 2009) 308 had actually attended.

- Attitudes of health workers and clients

  NGO client members said the attitude of health workers at the outpatient clinics was not accepting of IDU or sex workers. Only if they paid for services were they well treated. Some staff participants of the NGO said where there had been advocacy work done by the NGO, the attitudes of the health workers improved and if health workers knew that clients were referred by that NGO their attitudes were accepting and courteous.

  Some members also said the attitude of drug users is not good: “IDU can’t even wait in queues and expect to be seen first”.

1.1.2.4 NON-GOVERNMENTAL ORGANIZATIONS– SEX WORKERS

The NGOs visited in Almaty were unable to organize meetings for the consultation team with their clients – one NGO suggested a focus group on the street with the sex workers, but for the security of the sex workers this wasn’t considered appropriate. Another NGO said their clients were too fearful of exposure to attend focus group discussion.

- Provision of counseling and testing for VCT

NGOs working with sex workers provide a significant level of pre-counseling and information on HCT for clients, as part of their prevention activities. They work with clients through outreach workers on the street and in sex worker hotspots. It was said pimps and madams are usually supportive of VCT, as they want healthy workers.

One NGO had developed a collaboration with a private medical practitioner for a range of services, who refers clients to the City AIDS Center for HCT. This NGO said the staff had tried in vain to develop a direct collaboration with the City AIDS Center. Staff members said anonymous testing is available but must be paid for. For free testing clients must show identity papers to prove they are citizens of Kazakhstan. If clients from this NGO do not want to go to the private practitioner, they will choose their own facility. The NGO does not currently have the capacity to keep records of which other centers are attended, or the rate of return for HIV test results.

Another NGO said when their clients want VCT they always accompany them directly to the AIDS center. They follow up their clients and ask them to return with them to get their test results. They estimate that between 5-12 women and girls from their NGO, test per month and that about 40% of clients return for results. The NGO also tries to follow up with pimps

and madams, to encourage women and girls to return for results, or to come back to the NGO for post-test support. The staff said the AIDS center is mandated to follow up on HIV positive results, but that people who test HIV negative are not followed up.

- Barriers to voluntary uptake of HCT

  The major barrier for the sex workers in the areas visited is language. Many of the women and girls are trafficked at a young age from rural areas or come to the city for work. Their first language is Kazakh and they often have little or no Russian. Information literature is generally in Russian. NGO workers and many of the health workers do not understand Kazakh well.

- Fear and lack of knowledge of HIV

  Staff members of the NGOs said their clients were often trafficked to the city at a very young age, as young as fourteen years, from villages in the rural areas. They had not received much education and had low literacy levels. Many had little or no knowledge of HIV or HIV prevention. The clients would often move working areas, from fear of harassment and arrest by police and were difficult to gain access to, for information and material supports such as condoms. However over time the NGOs had mapped out the hotspot areas where their outreach workers could find sex workers and established a working relationship with pimps to facilitate HIV prevention interventions and information and counseling about VCT to their sex workers.

1.1.2.5 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS – MSM

MSM groups in Almaty have a strong advocacy and information-sharing background. Some also have links to other international organizations. Two organizations were visited and focus groups held with members.

- Access to VCT

  Discussion group participants said they preferred to use the services of the City AIDS Center or of a private practitioner for VCT referrals. From experience they found health workers, particularly the doctors, at the outpatient clinics were not accepting of their clients' sexuality, were too abrupt in their attitudes and did not maintain anonymity. Clients do not disclose their status but assumptions are made about their sexuality in many instances. One group said that their members regularly register complaints about the health workers at the outpatient clinics with the authorities.

  Anonymous VCT is provided at the AIDS center. NGO staff also noted that NGOs must have an agreement with a health facility to provide appropriate services to a specific client group. Without an agreement the services are of poor quality.

  Outreach workers and NGO staff provide access to information, conduct social events and awareness-raising activities at bars and other social venues to increase uptake of VCT.

- Training of NGO staff and relationships with health facility staff

  Clients and staff members noted that even at the AIDS center there is a significant turnover of health workers (both doctors and nurses) and acknowledged that establishing good relationships with individual health workers, while useful for "friendly" service in the short term, meant that relationship-building was a continuous process. One staff member suggested that training and re-training of staff on HIV and VCT was constantly needed. Another staff member said the NGO would like to be able to provide a full service for VCT and that while the NGO did a lot of preparatory counseling of clients, that they would also like to have their own staff trained to provide pre- and post-test counseling and to use rapid test kits. This NGO had also applied to the AIDS center to be trained as phlebotomists to

take their clients blood for HIV testing, but this had been rejected by the AIDS center. The current guidelines for provision of HCT only allow medical facilities to take blood samples.

1.1.2.6 NON-GOVERNMENTAL ORGANIZATIONS AND FOCUS GROUPS – PLHIV

- Referral for and uptake of VCT

  Some NGOs had achieved stronger collaboration with health services than others. One NGO said if a new client approached the NGO asking for VCT, that they would be referred to a friendly office or trust point. There was no system of escort or referral forms in use in this NGO. A second NGO established collaboration with the AIDS center and sends clients directly to the AIDS center. They do not work with the outpatient clinics. These clients use a voucher (referral form) issued by the NGO. Clients are not accompanied.

1.1.3 HEALTH SYSTEM ISSUES

1.1.3.1 QUALITY OF SERVICES – DISPARITY BETWEEN SERVICES

There seemed to be significant disparity in the accessibility, prevailing attitudes and services offered from one outpatient clinic to another. While one clinic had been highly innovative in developing an outreach model of access for difficult-to-reach clients, others seemed to play a much more passive role and wait for MARP clients to attend the service. One service seemed to actively put up barriers to implement the mandates for increasing VCT access for vulnerable groups.

1.1.3.2 TRAINING

There was a lack of equal opportunity for training between the health facilities. Some had implemented refreshers and new training for staff, others had not. Training in PICT seemed to be lacking in all but one facility. Training of nurses also varied considerably from one facility to another, with some facilities successfully expanding the role of the nurse, while in others, little seemed to have changed over the last ten years from the delivery of a vertical health service.

1.1.3.3 RAPID TESTING

- Most NGO staff were strongly in favor of expanding the delivery of VCT through the provision of training and material to use rapid HIV tests. Many staff members were not aware of all the requirements for the provision of rapid testing including: separate rooms, sterile equipment, stocks and supply management. The costs and management implications of staff training, of renting space, and buying materials would require continuous funding stream. The current regulatory framework does not allow for the implementation of this type of service.

1.1.3.4 FOLLOW -UP

Follow up is the responsibility of the physician who sends the client for testing. There was lack of evidence that this part of the VCT service was being implemented successfully.

- There was a complete lack of focus (and possibly a lack of understanding of the importance of counseling) for clients who tests HIV negative, in nearly all the health facilities that were visited. The focus was exclusively on follow up or, more realistically, data collection of those who tested HIV positive.

  It was difficult to get an accurate idea of how many people return for their HIV test results, because the team did not have the opportunity to obtain data from each health facility on referral numbers and return rates, and some of the estimates given seemed unrealistically

high. A return rate of 40% was quoted by one NGO working with sex workers. Both data collection and increasing return rates are issues that need to be addressed.

1.1.3.5 LACK OF INSTITUTIONALISATION OF PICT

A strong focus in the health facilities on the orders concerning the provision of VCT seems to overshadow the need for offering HIV testing and counseling. Only one health facility actively implemented PICT. No institutions used a risk assessment format for identifying clients in need of HCT.

1.1.3.6 LANGUAGE AND MATERIAL RESOURCES

The Kazakh language is used by many of the vulnerable groups, but is not well understood in health services. There is a need for written and low-literacy materials in Kazakh for the clients.

2.2RECOMMENDATIONS - KAZAKHSTAN

2.2.1 PRIORITY RECOMMENDATIONS FOR HCT IN LOCALITIES

TRAINING

- The most important aspect of training for health staff is to develop skills in communicating effectively with clients, especially on sensitive issues. Develop a short course combining: experiential learning on basic communication skills; skills specific to VCT and PICT (including conducting a risk assessment and counseling for a negative result); and on reduction of stigma and discrimination. Roll out the training to frontline workers at trust points, friendly offices, FMC, FGP and at dispensary level (where dispensaries exist in the entry point localities). Involve the relevant postgraduate medical education institution in this process.
- Develop training in communication skills for nurses. Roll it out to nurses in trust points, friendly offices, FMC FGP and at the dispensary level.

QUALITY ASSURANCE AND SUPERVISION

- Develop a system of mentoring and clinical (supportive) supervision for doctors involved in HCT, in collaboration with the relevant postgraduate medical education institution and a number of senior staff from health facilities. Roll out the training to a number of health facilities in the Quality Project localities. The aim being to expand this supervisory system to all health facilities and to include nurses, within the localities in Year 2.
- Develop a standardized risk assessment pro-forma, in consultation with representatives of health services and NGO staff and clients. Health workers, who have undergone training in communication skills, should receive additional training on the use of the risk assessment.
- Develop a monitoring and evaluation system focusing on the quality of HCT, based on qualitative indicators and include the contribution of NGOs and health workers.
- Develop a post-training evaluation (to be conducted 3 months after the training) for clinicians who have received training in communication skills (as described above).

REVIEW OF REFERRAL SYSTEMS

- Thoroughly review referral systems, including individual NGOs' referral forms, and the current practice of escorting clients to clinics in Year 1 and continue into Year 2. It should be conducted, in collaboration with NGO staff, within each locality and recommendations made on ways to improve and streamline the system.

2.2.1 RECOMMENDATIONS FOR HCT IN PROJECT YEAR 2

RAPID HIV TESTS

- Advocate to regulatory authorities on the need for rapid tests (at health facilities and NGO sites) and the development of appropriate training on how to use the tests. Lobbying for the assessment of NGOs as VCT delivery sites is also needed.

TASK SHIFTING

- Develop a strategy for task-shifting specific to HCT, with recommendations on incentives and salary issues: in consultation with appropriate regulatory and legislative bodies, relevant faculty members and representatives of the health workforce.

QUALITY ASSURANCE AND SUPERVISION

- Expand the system of mentoring and clinical (supportive) supervision for doctors involved in VCT to all other localities. Include the mentoring and clinical supervision of nurses in facilities in the localities, as part of a larger strategy of task shifting of roles.
- Collaborate with representatives of health services and NGOs to define and then implement quality services (such as partnership-defined quality).

TRAINING

- Develop a refresher training on communication skills (as described in Year 1) to deliver to frontline workers (doctors and nurses) currently involved in HCT at trust points, friendly offices, FMC, FGP and at dispensary level.
- Develop a short course combining: experiential learning on basic communication skills; skills specific to VCT and PICT (including conducting a risk assessment and counseling for a negative result); and on reduction of stigma and discrimination. Roll out the training to frontline workers in Temirtau locality who are currently working on VCT at trust points, friendly offices, FMC, FGP and at dispensary level (where dispensaries exist in that localities).
- Consult with the appropriate regulatory body for medical and nursing education, to discuss the development of pre-service trainings for doctors and nurses in HCT and communication skills
- Write a curriculum on HCT that includes: addressing stigma and discrimination (especially in relation to most-at-risk populations), and teaches communication skills. Curriculum to be developed in consultation with the appropriate health faculty for pre-service education for doctors and nurses.
- Translate material resources – client informational materials, HCT training materials, clinical guidelines and protocols and medical handbooks into Kazakh, and low-literacy information resources on HCT produced.

RECOMMENDATIONS ON INCREASING UPTAKE OF VCT

- Expand methadone programs and increase their accessibility. Methadone programs have been demonstrated to be successful in engaging clients with other health services including uptake of VCT.
- Consult with police to encourage a reduction in harassment of clients. Reduction of harassment of clients near health facilities will likely improve acceptance and access to VCT, as well as other health services
- In consultation with prison services and local NGOs, strategies should be developed to engage released prisoners to access HCT and health services

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TAJIKISTAN

Tajikistan is a fragile state with very little industry or available agricultural land. In recent years the economy has reached near-collapse. It is estimated that at least a million workers migrate each year for work in Russia and Kazakhstan. Migrants require an HIV test to enter neighboring countries such as Russia, but there is only follow-up of migrants if the person initiates attendance for HCT on his return to Tajikistan. Numbers of opiate users have risen to an estimated 0.5% (20,000-25,000 people) of the total adult population aged 15 to 64. In addition many women, especially rural women, have entered sex work as result of the economic downturn in the country. There is estimated to be between 10,000 to 15,000 female sex workers throughout Tajikistan.

Amendments to the 'Law of the Republic of Tajikistan No. 476' December 31st, 2008 outlines the state provision of free, quality medical and psychosocial assistance to people with HIV. The law stipulates services to PLHIV shall be anonymous, confidential and voluntary. Related to this, is the government decree "On approval of medical examination system in order to reveal infection with human immunodeficiency virus, registration, and medical examination of HIV-infected and preventative observation of them', April1st, No. 171. This document currently serves, as the basis for HCT.[1] VCT is a free service.

3.1. DUSHANBE

I.I.4 VCT AND PICT

1.1.4.1 HEALTH CARE INSTITUTIONS – GOVERNANCE /MANAGEMENT LEVEL AND SENIOR CLINICIANS

The discussion opened with an announcement by the Director of the City AIDS Center that a new action plan for Dushanbe has been developed, as part of the new national health plan, which includes strategies for meeting the needs of vulnerable populations. The City AIDS Center covers 40% of the population of Dushanbe.

- Access to VCT

Many clients first engage with an NGO for pre-test counseling and support, before going for VCT. Rapid tests are carried out by one of the health facilities, for example the reproductive health services or youth friendly services. For a second test, the client is referred to the City AIDS Center.

It was said staff have been trained in PICT, although there is no risk assessment performed. If clients attend a health center with TB or other diseases associated with HIV, the physician offers CT. if the client agrees s/he is referred to the City AIDS Center. Results are returned to the clinician. HIV negative results are not discussed with the client.

Dushanbe also has six youth-friendly health services and they provide information and education on HIV prevention and coordinate work with sex workers, IDU and MSM. They work with clients up to twenty-four years of age. Staff in the youth-friendly services are trained in VCT. They work in close collaboration with the reproductive health centers, so that youth can also benefit from rapid HIV testing.

The youth friendly services also collaborate with NGOs to encourage uptake of VCT. They work in hot spots where sex workers work and where IDU gather, but find access to MSM difficult: …"they are a very hidden group".

- Training

All reproductive health centers have rapid HIV tests and provide this service, and almost all of the centers' gynecologists had been trained in VCT. In addition one infectious disease specialist from each polyclinic (large outpatient clinic with many specialists), has been trained to follow up people who test HIV positive, and is responsible for the provision of information and training of other staff in matters relating to HIV. There is also trained staff at FMPs.

The coordinator of the youth friendly services said quality training has improved the delivery of VCT significantly. Gynecologists were afraid to deal with clients who might be HIV positive. Decentralization of services had also helped to remove stigmatizing treatment, because it is no longer possible for health workers to just send clients to specialists at the City AIDS Center. Those who have been trained now maintain respectful attitudes towards clients. She acknowledged there are still gaps in their system – not all professionals have been trained in all facilities.

1.1.4.2 NON-GOVERNMENTAL ORGANIZATIONS ROUNDTABLE

Six representatives of five NGOs respectively working with sex workers, IDU PLHIV and MSM attended this roundtable.

- Access to VCT

Staff members said in the past there were many problems with the Republican AIDS Center. Post-test counseling and support for clients was insufficient and there were several suicides. Now that decentralization had increased options for clients and the NGOs' advocacy work had established better understanding of their clients' needs, there was better quality service. One staff member said there was no need to sign an agreement with any service, as VCT was free in all health facilities that provided it. However, participants acknowledged that social management (accompanying the client to appointments) was still needed, to ensure the client received good quality, non-judgmental care. Many clients came to the NGOs first when they were considering VCT. NGOs do not provide HIV testing but they provide substantial preparatory counseling for clients.

One participant said stigma still remains with regard to other services and certain services will be refused for clients such as IDU, but confirmed that the system for VCT works well.

- Referral systems

Clients can self-refer or go through an NGO. Clients wishing to go to VCT are given a referral form from their respective NGOs and are accompanied to the appointment. NGOs usually work with preferred polyclinics they have established connections with. Several NGOs prefer to work with the National AIDS Center rather than the City AIDS Center as geographically the National Center is closer to the clients' hotspots and the NGO offices. Furthermore only the National AIDS Center has the equipment to perform an immunoassay test. At the National AIDS Center clients are given an option of a rapid test or a first blood sample test. The attending physician, discusses the results of the rapid test with the client. The NGO leaves it to the client to decide if s/he will return for the result of a blood test.

The PLHIV NGO receives referrals of positive people from the National AIDS Center, which they have a close working relationship with.

1.1.4.3 FOCUS GROUP - IDU

The NGO staff and clients joined this focus group.

- Access to and uptake of VCT

Participants said IDU who knew about the NGO had the opportunity to receive support and free treatment at the preferred polyclinic. Staff acknowledged that there were many more IDU who did not have access to the NGO, who did not know about access to VCT and health services.

Some participants suggested that what was needed was a mobile NGO service, for example a minibus, to take information and education to the hotspots where clients gather.

Those clients, who are associated with the NGO, receive significant counseling support from staff pre-VCT. They are given a referral form and are accompanied to the health facility. The same physician who sees the person initially, gives them their HIV positive results.

- Rapid tests

Participants said in the majority of cases, clients would prefer to have their counseling and testing at the NGO offices because they felt comfortable there and were already receiving HIV counseling there. Staff said they would prefer to have rapid tests and be trained to use them. They would be able to provide much-needed counseling for people with an HIV negative result as well as counsel clients with a HIV positive result, in a more conducive and less alien environment. One staff member added that:

....”The physicians are tired; they don’t do proper pre-test counseling”.

1.1.4.4 FOCUS GROUP – SEX WORKERS

- HIV testing

Participants said they usually attended the reproductive health center for general health needs and were well treated. They said when a woman is pregnant she is obliged to have an HIV test. All the sex workers in the group said that they have re-tests every three to six months and are supported in this by their pimps and madams.

- Payment for services

Payment for services is common, even for services that are meant to be free,. One participant said: “Sometimes we have to pay, but that’s okay, the doctors need money”. There was a general perception that if they pay, they will be provided with better quality services.

1.1.4.5 FOCUS GROUP – MSM

This NGO had grown out of an identified need to provide members with legal support against stigma and discrimination.

- Access to VCT

Currently members of the group attend the National AIDS Center where there is a trusted doctor who sees them. This relationship has been established over time, by the staff of the NGO. Trusted doctors provide medical services at other facilities as well. While there is access for those clients associated with the group, participants acknowledged that there were other men who were difficult to reach. Most MSM were married and had children and “lived a double life”.

Before a client attends for VCT, the NGO staff provides support and counseling. They also provide group education on HIV testing. Some participants said they regularly attend for testing – every three months was the usual frequency.

- Barriers to VCT

Constraints against clients attending for VCT included: fear of disclosure of their sexuality; dislike of being questioned about their sexual activity particularly by women, and past experiences of harassment by police or health workers, threatening to disclose the client’s sexuality to his wife and family.

- Rapid tests

The members of the group were unanimous in their desire to have rapid test available for their use. They were knowledgeable about rapid tests; some staff had been to a conference in Ukraine and had witnessed demonstrations of the ease of use of rapid tests. They felt that since

they already effectively provide the pre-test counseling, that they should be able to provide the initial test as well.

1.1.4.6 FOCUS GROUP – PLHIV

This group comprised members of a NGO focusing on women living with HIV

- Coercion into VCT

Most participants said they had not attended voluntarily for HIV testing, but had been coerced into this when pregnant or needing surgery. When asked if their permission had been asked to take blood for HIV testing, many replied that it was mandatory to be tested for HIV if pregnant. One said she had wanted to leave the country for work so had to have a test.

- On receiving a test result

Some participants said that on receiving the HIV positive test result, they had been given a food package and sent away. Another said that since learning about her positive status after her husband had died of AIDS, her mother-in-law had thrown her out of the house. She had taken this issue to court but felt that the legal attitude was in favor of the mother-in-law.

No follow up counseling was provided for people with an HIV negative result.

3.2. VAHDAT

Vahdat is on one of the main drug trafficking routes through Central Asia. There are high levels of unemployment and many men leave the area each year for work, in neighboring countries. A local government AIDS center was established in Vahdat in 2005, under the National AIDS center. Blood testing is carried out here. There are two friendly offices – one for sex workers and one for labor migrants. There is also a trust point for IDU. These offices send clients to the AIDS center for testing. Pre- and post-test counseling is provided at the AIDS Center.

3.2.1. VCT AND PICT

3.2.1.1. HEALTH CARE INSTITUTIONS – GOVERNANCE /MANAGEMENT LEVEL

- Access to and uptake of VCT

There is an initiative in Vahdat to target labor migrants for VCT. Those who want to work in neighboring countries, attend the friendly office for testing and based on their HIV negative status are allowed permission to migrate. The Head of the AIDS Center said many, but not all returning migrants come back to the friendly office for re-testing. People who are Russian citizens can attend for testing under the current regulatory framework of the Department of the Interior, so that they can obtain test results to take back to Russia. The AIDS center does not maintain data on numbers of migrants (it is kept by the local immigration bureau), but the director reported the figure of 40,000 workers who migrate from the area annually.

Attendance numbers of IDU is not high – the Director of the AIDS center said in the past five years, 120 IDU had been seen at the AIDS center and 110 had completed HIV testing, but that there was estimated to be at least 1000 IDU in Vahdat. In total there were 300 PLHIV identified in Vahdat.

- Barriers to access and uptake of VCT

There was agreement among participants that several barriers to access to VCT existed.

The Director of the FMC said there was still a great deal of stigma and discrimination on the part of family doctors, and other health workers, and that there was also self-stigma on the part of members of vulnerable populations.

He added that neither staff nor clients were informed or knowledgeable about the concept of confidentiality. Family doctors and nurses at family practice did not understand the principles of non-disclosure of HIV status unless it is necessary for client care and treatment:

> …"They will ask 'why can't we know the HIV status?' but first they should ask about disclosure [and why they need to understand the concept]"

At the same time, one of the senior participants in the discussion said he would like a list of PLHIV that could be shared between all the health workers so that it would simplify the work, demonstrating a greater concern with data collection and fulfilling bureaucratic demands than a respect for confidentiality.

- Training

Training of clinicians is also a factor in the lack of uptake of VCT. One of the health facility heads said the training provided consisted of theoretical lectures on HIV (some of which address perceptions around HIV), but that the training was insufficient. He said more training to understand issues like: confidentiality, respect for non-disclosure, and how to talk about difficult or taboo subjects was also needed.

Representatives of the Postgraduate Medical Institute were currently providing training in HIV for both doctors and nurses at the FMC.

3.2.1.2. NON-GOVERNMENT ORGANIZATIONS AND FOCUS GROUPS – IDU, SEX WORKERS AND PLHIV

One meeting was held with staff from three NGOs working with PLHIV sex workers and IDU and a focus group with PLHIV and IDU NGOs. There was no access to any groups working with MSM and NGOs and clients did not know of any MSM groups in the area.

- Access to VCT

Some client participants said they first went to VCT on their own, often because they had had no contact with the NGOs. Other clients said they had first made contact with the NGOs to obtain information and discuss their fears around HIV and HIV testing. Several clients said the VCT at the AIDS center had been a good experience and that they had received an appropriate level of information and good quality counseling. Others in the group felt that this was due in large part to the advocacy work done by the NGOs and that without the collaboration that the NGOs had developed with health services, the attitudes of the health workers would be very different.

- Barriers to access to VCT

One of the IDU clients in the group said there were many obstacles preventing IDU from seeking out VCT. He explained that the priority to get drugs superseded all else; their chaotic life made attending appointments difficult; their concern of health workers finding out and disclosing their drug use (especially to family members) and their fear of being harassed by police at the health facility, all prevented him from go to VCT. Several participants agreed that there was still a significant mistrust of health workers with regard to stigma and to lack of confidentiality.

- Fear of stigma and discrimination

One participant made the point that for women, stigma was even more pronounced. Many women discover their HIV positive status when coerced into HIV testing when pregnant or when undergoing surgery. They are often not offered information on PMTCT and are unlikely to attend a health facility for discussion about antiretroviral therapy, for fear of disclosure of their positive status.

NGO staff members said the organization had worked hard over the last number of years to develop good relationships with health facilities, the police and community members and had helped to positively influence the community in reducing stigma and discrimination. There were now agreements in place between both NGOs and selected facilities. The police and community leaders had demonstrated support for the NGOs. However there were still incidences where clients who attended health services without an NGO escort, were treated badly and this required continuing advocacy efforts.

3.2.2. HEALTH SYSTEM ISSUES

3.2.2.1. TARGETED INTERVENTIONS ON ACCESS TO VCT FOR ADULTS IN MOST-AT-RISK POPULATIONS

While it is evident that a great deal of work has gone into work with youth with high-risk behaviors there seemed to be markedly less emphasis on reaching older adults, not only including the groups visited in this visit (IDU, sex workers and MSM), but also migrant populations and prisoners or ex-prisoners. The recent national and local strategic plans may contain strategies for these populations, but were not yet released or available for review. Counseling for HIV negative results seems to be lacking or absent.

3.2.2.2. STIGMA AND DISCRIMINATION

While some of the health facilities have had significant intervention to reduce stigma and discrimination through training and capacity building of staff, there are other areas of health services that still need substantial improvement, particularly in relation to IDU and MSM.

3.2.2.3. LACK OF INSTITUTIONALISATION OF PICT

Health facilities, even those who have undergone training in the provision of VCT, seem generally to respond passively to clients, mostly expecting the client to initiate discussion around VCT. Even in those instances where clinicians have identified a need for the client to attend for HCT, there is no risk assessment or history taking, only some questions framed according to the clinician's 'suspicions" and a referral made to another center.

3.3. RECOMMENDATIONS - TAJIKISTAN

3.3.1. PRIORITY RECOMMENDATIONS FOR HCT IN LOCALITIES

TRAINING

- The most important aspect of training for health staff is to develop skills in communicating effectively with clients, especially on sensitive issues. Develop a short course combining: experiential learning on basic communication skills; skills specific to VCT and PICT (including conducting a risk assessment and counseling for a negative result); and on reduction of stigma and discrimination. Roll out the training to frontline workers at trust points, friendly offices, FMC, FGP and at dispensary level (where dispensaries exist in the entry point localities). Tailor the stigma and discrimination component of the training to the relevant locality, for example, in the south of Kyrgyzstan, stigma and discrimination against MSM and migrants is intense and would require specific address.
- Training in Vahdat has not been as robust as in Dushanbe, therefore training for doctors in Vahdat should be developed to include basic information on HIV and HCT, basic skills in counseling, communication skills on difficult/sensitive issues, introduction to confidentiality and disclosure and on stigma and discrimination, as well as more advanced training on VCT and PICT.
- Involve the relevant postgraduate medical education institution in this process.

- Develop training in communication skills for nurses. Roll it out to nurses in trust points, friendly offices, FMC FGP and at the dispensary level. A more intensive training input in Vahdat may be necessary (as described above)

QUALITY ASSURANCE AND SUPERVISION

- Develop a system of mentoring and clinical (supportive) supervision for doctors involved in HCT, in collaboration with the relevant postgraduate medical education institution and a number of senior staff from health facilities. Roll out the training to a number of health facilities in Quality Project localities. The aim being to expand this supervisory system to all health facilities and to include nurses, within the localities in Year 2.
- Develop a standardized risk assessment pro-forma, in consultation with representatives of health services and NGO staff and clients. Health workers, who have undergone training in communication skills, should receive additional training on the use of the risk assessment.
- Develop a monitoring and evaluation system focusing on the quality of HCT, based on qualitative indicators and include the contribution of NGOs and health workers.
- Develop a post-training evaluation (to be conducted 3 months after the training) for clinicians who have received training in communication skills (as described above). .

REVIEW OF REFERRAL SYSTEMS

4. Thoroughly review referral systems, including individual NGOs' referral forms, and the current practice of escorting clients to clinics in Year 1 and continue into Year 2. It should be conducted, in collaboration with NGO staff, within each locality and recommendations made on ways to improve and streamline the system.

1.1.2 RECOMMENDATIONS FOR HCT IN PROJECT YEAR 2

RAPID HIV TESTS

- Advocate to regulatory authorities on the need for rapid tests (at health facilities and NGO sites) and the development of appropriate training on how to use the tests. Lobbying for the assessment of NGOs as VCT delivery sites is also needed.

TASK SHIFTING

- In consultation with appropriate regulatory and legislative bodies, relevant faculty members and representatives of the health workforce a strategy for task-shifting specific to HCT should be developed, together with recommendations on incentives and salary issues.

QUALITY ASSURANCE AND SUPERVISION

- The system of mentoring and clinical (supportive) supervision for doctors involved in VCT should be expanded to all other localities. Mentoring and clinical supervision for nurses in facilities in the localities should be included as part of a larger strategy of task shifting of roles.
- Collaborative development of defining quality of services (such as partnership-defined quality) should be developed and implemented involving selected representatives of health services and NGOs.

TRAINING

- Develop a refresher training on communication skills (as described in Year 1) to deliver to frontline workers (doctors and nurses) currently involved in HCT at trust points, friendly offices, FMC, FGP and at dispensary level.
- Consult with the appropriate regulatory body for medical and nursing education, to discuss

the development of pre-service trainings for doctors and nurses in HCT and communication skills

- Write a curriculum on HCT that includes: addressing stigma and discrimination (especially in relation to most-at-risk populations), and teaches communication skills. Curriculum to be developed in consultation with the appropriate health faculty for pre-service education for doctors and nurses.
- Translate material resources – client informational materials, HCT training materials, clinical guidelines and protocols and medical handbooks into Tajik, and low-literacy information resources on HCT produced.

RECOMMENDATIONS ON INCREASING UPTAKE OF VCT

- Expand methadone programs and increase their accessibility. Methadone programs have been demonstrated to be successful in engaging clients with other services, including uptake of VCT.
- Consult with police to encourage a reduction in harassment of clients. Reduction of harassment of clients near health facilities will likely improve acceptance and access to VCT, as well as other health services
- Develop behavior change and communication strategies to gain access to returning migrants for Year 2 planning.

NEXT STEPS

In Central Asia at present, certain populations are identified as at particular risk of HIV infection and transmission (most-at-risk populations or MARPs, including PLHIV). These populations are marginalized from health services due to stigma and discrimination and isolation caused by the illegality of their behavior. This access gap is filled to some extent by donor interventions that provide outreach to isolated populations, however the geographic reach and breath of services offered by these programs has been limited and is not at a scale that is likely to significantly reduce HIV incidence and impact in the long-term. The health system has not generally been an active partner in these outreach programs and there is often a significant difference in the quality of services that MARPs receive from donor interventions compared with that received once in the health system.

The demand created by these outreach programs is not generally met by an increase in high-quality supply. Referral is often a passive exercise of notifying MARPs of the location of services, rather than an active exercise of assisting services to better provide care for MARPs and assisting MARPs to gain entry and maintain contact with these services.

Few of these programs focus on achieving long-term change in the relationship between MARPs and the health system. This is often brought about by the empowerment of MARPs so that they can more effectively participate in health system reform and health service planning, delivery and evaluation. There has also been inadequate focus on removing the barriers to access that exist – going beyond stigma and discrimination to look at issues of task allocation, core competencies and health financing.

Pockets of access exist – some primary health care or family medical care centers (PHC/FMCs) gain a reputation for being particularly friendly towards a certain MARP group, such as PLHIV. This may be because of the motivation of the Director or other personnel within the service or because of the work of a neighboring civil society organization (NGO). This PHC/FMC acts as an entry point for other services but it is not clear how wide this improved access or quality spreads or how it can be replicated in other geographical areas.

The USAID Quality Health Care Project (Quality Project) will work in specific Localities to examine and support these pockets of improved access – open entry points – and work with communities, NGOs and services to open these entry points further so that MARPs can access the full range of services they need when they need them. It will work with the key staff in these entry points to determine the factors that led to this increased access and take the lessons from this to other services in the same locality. It will work with NGOs involved in outreach programs, through the USAID Dialogue on HIV and TB, Global Fund to fight AIDS, TB and Malaria (GF) projects and other initiatives, to develop more effective referral strategies, brokering systems and other initiatives to ensure that MARPS reach these services and develop long-term health-seeking relationships with them.

In Year 1 a short course on basic communication skills and skills specific to VCT and PICT has been developed and this will be delivered to doctors and nurses in all Year 1 Localities (9 in all), then repeated in Year 2 (to ensure all doctors and nurses in each Locality have access to the training). This training program has been developed within the framework used by institutions providing ongoing medical education in each country, developed under previous USAID-funded projects.

After trialing the training materials in the Localities, assistance will be provided to training institutions to provide access to this training for all primary health physicians and nurses throughout each country – or as many of these as are able to be reached by ongoing medical and nursing education programs.

Eventually, this training course should also be offered to medical and nursing under- and

postgraduate training institutions. A mentoring and clinical (supportive) supervision for doctors involved in VCT in one or two health facilities in each of the Quality Project Localities is being established.

In Year 2, it is planned to:

- Develop a VCRT (Voluntary Counseling and Rapid Testing) system of using rapid tests in outreach together with confirmatory tests at PHCs and other health facilities, including advocating (where needed) to regulatory authorities on the need for rapid tests (at health facilities and NGO sites) and the development of appropriate training on how to use rapid tests.
- Develop a standardized risk assessment pro-forma. Health workers who have undergone training in communication skills should receive additional training on the use of the risk assessment.
- Develop a monitoring and evaluation system focusing on the quality of HCT based on qualitative indicators and measures.
- Develop a post-training evaluation for implementation after three months with clinicians who have received training in communication skills (as described above).
- Expand the system of mentoring and clinical (supportive) supervision for doctors involved in VCT to all Quality Project localities. Mentoring and clinical supervision for nurses in facilities in the localities should be included as part of a larger strategy of task shifting.
- Collaborate with representatives of health services and NGOs to define and then implement quality services (such as partnership-defined quality).
- Thoroughly review referral systems, including individual NGOs' referral forms, and the current practice of escorting clients to clinics in Year 1 and continue into Year 2. The review should be conducted, in collaboration with NGO staff, within each locality and recommendations made on ways to improve and streamline the system.

Other recommendations will be addressed in national and regional work by the Quality Health Care Project team.

ANNEX A: MEETINGS AND FOCUS GROUPS SCHEDULE KYRGYZSTAN

TABLE 1: MEETINGS AND FOCUS GROUPS IN KYRGYZSTAN

March 28 – April 2, Kyrgyzstan

Name	Position	Time	Contact information
March 27 Arrival to Jalal-Abad			
March 28			
Kainazarova Aisuluu	Head of NGO Zdorovoe Pokolenie (Healthy Generation)	9:30	Mob. 0772 43 23 00 vich1@rambler.ru
Miyanov Mamadjan Orunbaeva Zamira	Director of Jalal-Oblast FMC Head of FGPA in Jalal-Abad	11:00	Mob. 0550 45 21 73 Mob. 0772 20 52 08
Round Table Meeting on VCT	14 participants from governmental & nongovernmental organizations	13:00 – 16:00	Conference Room of Oblast FMC
Davletova Ainura	Head of Jalal-Abad oblast Reproductive Health Center	16:00 – 17:30	Mob. 0773 99 77 22
March 29			
Ermatov Baigazy	NGO "Tais Plus -2"	9:00 – 10:30	Mob. 0 555 64 76 79
Focus Group with SW		11:00 – 12:00	
Murkamilova Venera	Head of FMC #1 *(Entry Point)*	13:00 – 14:00	Mob. 0778 92 88 29
Focus Group with IDUs		14:00 – 15:30	
Focus Group with PLHIV		15:30 – 16:45	
Satarova Elmira	Head of Jalal-Abad Oblast AID Center	17:00-18:00	Mob. 0773 45 40 74
March 30			
8:00 - Moving to Kara-Suu rayon			
Baatyrova Gulnara Cholponbaeva	Director of Kara-Suu FMC *(Entry Point)*	11:00	Mob. 0555 01 41 41

Byubyuaisha	Head of FGPA in Jalal-Abad		Mob. 0772 20 52 08
Narmatova Elmira	Head of Osh Oblast AID Center	13:00	Mob.0550 84 03 01
Sharonova Nadejda & ***Focus Group with SW***	Director of NGO "Podruga"	14:00	Mob.0555 61 35 38 Masalieva st. 55\65
Burkhanov Mamasabyr ***Focus Group with IDUs***	Head of NGO "Roditeli protiv narcotikov"	15:30	Mob. 0555 81 0762 Yugo-Vostok, Petrova str.
Majitov Ravshan ***Focus Group with PLHIV***	Head of NGO "Plus Center»	17:00	Mob. 0543 17 50 40 Mominova str.22
Gulamov Karim Fokin Vlad ***Focus Group with MSM*** Koshokova Fatima	Contact person Head of NGO "Zolotaya Antilopa" Head of NGO "Reinbow"	19:00	Mob.0555 1759 58 0551068617 Masalieva st. 54\12 Mob.0772 89 54 20 Office 03222 457-76 0322221792
March 31			
Galieva Altynai	Head of NGO "Life plus"		Моб. 0550 28 51 31
Round Table Meeting on VCT	10 participants from governmental & nongovernmental organizations	10:30 -12:30	Conference Room of Oh Oblast AID Center
Flight to Bishkek at 18:20			
April 1			
Sorombaeva Ainur	Director of FMC #6, Bishkek city, *(Entry Point)*	9:00	Mob. 0550 45 21 73
Tokubaev Ruslan	Head of Republican Narcology Center	10:00	Mob.0777 97 12 62
Estebesova Batma	Director of NGO "Sotcium"	11:00	Mob.0555 97 07 07
Round Table Meeting on VCT	10 participants from governmental & nongovernmental organizations	14:00, office at Tynystanova 195	Conference Room of USAID QHCP, Tynystanova str.195

Focus Group with SW		17:30 – 19:30	Islamova Shakhnaz Mob. 0555 88 93 07
April 2			
Focus Group with PLHIV		11:00 – 13:00	Isaeva Burul
Focus Group with MSM		13:30 - 15:00	Bratukhin Maksim Mob. 0555 954 362
Focus Group with IDUs		16:00 - 17:30	Madina Tokombaeva Mob. 0552 49 79 79

ANNEX B: MEETINGS AND FOCUS GROUPS SCHEDULE KAZAKHSTAN

April 4 – 7, Kazakhstan

Name	Position	Time	Contact information
		April 4	
Round Table Meeting on VCT	14 participants from governmental organizations	14.00 – 17.00	Conference Room of Almaty City AIDS Center
		April 5	
Meetings with medical specialists, Friendly clinic, Trust point	5 doctors and 3 nurses	10.00 – 12.00	Outpatient clinic #8, Almaty Head of the clinic – Bizhigitov Zhaksybai 7 727 240 89 20
Logachev Denis	Head of NGO "Omir LAD" (IDU)	15.00 – 16.30	Mob. 7 702 158 89 99
Ragoza Valentina Focus group with MSM	Head of NGO "Amulet" (MSM)	18.30 – 20.00	Mob. 7 701 779 45 61
		April 6	
Meetings with medical specialists, Friendly clinic, Trust point	6 doctors and 4 nurses	11.00 – 13.00	Outpatient clinic #9, Almaty Head of the clinic – Kozhasova Korlan 7 727 235 97 98
Marasheva Aigul Oleinikova Roza Focus group with PLWHIV	Head of NGO "Mental Health" (PLWHIV) Head of NGO "Doverie Plus" (PLWHIV)	14.00 – 15.00	Mob.7 705 910 30 23
Gapparova Gulya Focus group with IDU	Head of NGO "Social support TUMAR" – (IDU)	15.30 – 16.30	Mob.7 705 195 63 55

Smirnova Irina	Head of NGO "Arnamys" (SW)	17.00 – 18.00	Mob.7 705 622 31 65
April 7			
Suprunchuk Larisa	Head of NGO "Birge Damu" (SW)	11.00 – 12.00	Mob.7 705 226 26 65
Vinogradov Vitalii Focus group with MSM	HIV Manager of NGO "Adali" (MSM)	17.00 – 19.00	Mob.7 701 723 43 53

ANNEX C: MEETINGS AND FOCUS GROUPS SCHEDULE TAJIKISTAN

Tajikistan 11 -13 April, 2011

Name	**Organization and Title**	**Contact information**
Dushanbe		
	Meeting with representatives of Dushanbe city medical structures (April 13)	
Bukhoriev Kobiljon	City AIDS Center, Director	935059197
Talbov Umed	City AIDS Center, Head of Dispensary Department	918666174
Murodov Djaloliddin	City Dermatovenerological Center, Director	
Nabieva Firuza	City Center of Reproductive Health, Deputy Director/ responsible for Youth friendly services	
Sharipov Hushvaht	City Health Center #10, Director	
Huseinov Narzullo	City Health Center # 4, Director	919032905
	Round table with NGOs (April 11)	
Jamolov Pulod	NGO "Spin plus"(IDUs, PLHIV) Director	93505 9111 spinplus.admin@gmail.com
Kamilova Sevara	NGO "Guli Surh"(PLHIV), Director	935555809
Dzhuraeva Rizvon	NGO "Guli Surh", Coordinator	
Bobokhodzhaeva Maksuda	NGO "Nabzi Solim"(SWs), Director	919037523
Davlatov Fazlidin	NGO "Marvorid"(SWs), Coordinator	907314078
Kurbon	NGO "Legal support"(MSM), Cooordinator	378805061
	Focus Groups	
	PLHIV (office of NGO "Guli Surh")	

	IDUs (office of NGO "Spin Plus")	
	MSM (office of NGO "Legal Support")	
Vahdat (April 12)		
Radjabov Abdurashid	City AIDS Center, Director	(3139) 27039, 951623360
Kurbonov Valijon	City Health Center, Deputy Director	
Boev Rahmatullo	Head of Family Medicine Department	
Himich T.	Dermatovenerological Dispensary, Deputy Director	
Tabarova M.	Dermatovenerological Dispensary, Physician	
Zaidov M.	Dermatovenerological Dispensary , Physician	
Nurova Zarina	Family Medicine trainer of FM Center	
Pulatova Saodat	Family Medicine trainer of FM Center	
	NGOs representatives	
Hodjaev Rustam	Branch of NGO "Spin plus"(IDUs, PLHIV)	901099092
Davlatova Gulnora	Branch of NGO "Guli Surh"(PLHIV), Coordinator	
Saidov Safarbek	Branch of NGO "Marvorid" (SWs), Manager	
	Focus Groups	
	PLHIV (office of NGO "Guli Surh")	
	SWs (office of NGO "Marvorid")	
	IDUs (office of NGO "Spin Plus")	

ANNEX C: BIBLIOGRAPHY

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2. IDA and DFID. *Study and Evaluation of Central Asia Health Facilities' Capacity in Provider –initiated HIV Testing and Counseling. Kyrgyzstan*. Central Asia AID Control Project. 2005-2010.